HOSPITALS*

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ONE of the things that can be said about our subject, alternative delivery systems, is that it is having a different expression in different parts of the country, and the pace of change is different. I come from Massachusetts, and I shall discuss what is going on around Boston but with the caveat that what happens in Boston does not necessarily happen in the rest of the country. Another way of stating this: Just because the rest of the country goes one way does not mean that Massachusetts is going to take the same direction.

New York is one of the very few states with which we in Massachusetts could establish a common ground. It has been my pleasure and privilege to be in nearly constant communication with George Allen, who has been the president of the Hospital Association of New York State. We have important things in common. One was that we have had perhaps the most regulated hospital systems in the country. We have had a lot of trade secrets and problems to discuss together. Neither state has had a significant infusion of investor-owned hospitals, which makes a difference to the value systems we have tried to advance. One of the reasons investor-owned hospitals stay out of Massachusetts is the very sound reason that hospitals cannot make money up there, and that keeps them away pretty effectively, although we have investor-owned psychiatric hospitals. We also have some successful operations by the Hospital Corporation of America in contract management. Six Massachusetts hospitals now are managed under contract by H.C.A., and, while they are doing a good job with this, they are not about to buy into our system.

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We have had a spectacular recent HMO growth. After many years of getting started, with the Harvard Community Health Plan as our only real entry, we now have in our state 37 operational HMOs or managed care plans of one kind or another which have achieved a 26% market penetration. We are beginning to see the separation of the sheep from the goats, however. One HMO that will be nameless is in trouble now and had to go to its four sponsoring hospitals to be bailed out. Some HMOs are doing better than others. The most stable one currently is the Harvard Community Health Plan, a staff model HMO The one that is growing most rapidly, and, in the view of some, precariously, is an independent practice association HMO, called the Bay State Health Plan.

We now have considerable confusion about who does what in the health care field in Massachusetts. For years Blue Cross-Blue Shield in our state, as in New York, was the primary marketing arm for community hospitals and fee-for-service medicine. Long ago it had achieved substantial market domination. Then Blue Cross-Blue Shield of Massachusetts discovered a few years ago that if they wanted to keep their market share, they had to go into the health care delivery business. And, to the chagrin of many of our hospitals, they are now running quite a few HMOs, in effect competing with the health care delivery organizations which they also continue to sell in the marketplace. This has caused some ill feeling between the hospitals and Blue Cross, and a certain amount of confusion too because many of our hospitals are getting into the insurance business and running their own HMOs. I happen to believe that any hospital in these times that tries on a solo basis to start its own HMO and to operate it will be a loser. The big HMOs will be the ones that survive.

Blue Cross has a new offering called Master Health Plus, which has at least temporarily restrained the HMO growth around the state, because Master Health Plus offers a free choice of physicians. The reason it is selling so rapidly is that for the first time it is covering office visits. And it advertises on television that it only will cost the subscriber five dollars a visit. This has taken a lot of business away from hospital outpatient departments, where they used to pay full charges, but which they no longer do.

Another source of bad feeling is that Blue Cross, in this Master Health Plan package, includes pre-admission certification, mandatory second surgical opinions, concurrent review, and compulsory discharge planning on inpatient admissions. The program is going like gangbusters, selling very rapidly, and has deterred the growth of other offerings by HMOs around the state.

We have an anomalous situation in our state, where anything and everything the hospitals want to do is subject to regulation. With respect to capital and price, we are still controlled, although we gave up our waiver last October. We still are also limited on our allowed aggregate revenues. The problem now is that anybody who rides under the banner of an HMO is exempt, both on capital development and on price.

What is happening in our state, and was a great cause for concern when I was at the Massachusetts Hospital Association, and it still is, is that the HMOs, either overtly or just by the nature of what they are, are creaming the health care marketplace. And they are able to compete with hospitals very successfully because they are attracting the most healthy segments of the population. Some of the HMOs are intentionally excluding bad risks, but not all of them. This has created a very unequal situation on regulation in our state, where the hospitals are subject to requirements that the HMOs are not, and the hospitals and traditional insurers are getting the bad risks, or most of them. This is having the effect in our state where the great surge toward a more competitive system is in effect of segmenting the market.

As time goes by, the high risks are being more than ever isolated. Nobody wants them. I sometimes think that what will happen to our hospitals up there, particularly our referral hospitals, is that they are going to get all the old people, all the poor people and all the really sick people, and all of the rest of the people will belong to HMOs. Some of this has already started to happen. The "doc in the box" operations or urgicenters, surgicenters and emergicenters that are much talked about around the country have not, interestingly enough, gotten very far off the ground in our territory. This mainly relates to the point that the public has doubts about this new entry in the health care delivery field.

Not many of the surgicenters have opened yet, although, as I said, HMOs can start them without getting a certificate of need. Our public seems a little bit wary of the free-standing facilities. After a big push to get them started and with a heavy capital investment, they are losing a lot of money, and some of them are being closed. Thus, the concern that the hospitals had about this kind of competition has waned somewhat.

Another phenomenon that may have its parallel in New York City is that in spite of all the new emphasis about price competition disciplining the market and encouraging shoppers to go to the "most efficient" providers, expensive providers are still getting the lion's share of our business. To be more specific, the referral hospitals in Boston, the famous hospitals affiliated with Harvard, for example, with which I work now, are still running mostly

around 90% occupancy. Many of our community hospitals in the suburbs have now dropped to around 50% percent occupancy.

This relates to a couple of things that I cannot fully explain. I believe one of them has something to do with the malpractice crisis in our state, where physicians who once felt comfortable about taking care of a case out there in Newton/Wellesley or Waltham are saying, "If the case begins to look a little tough, maybe I just better ship it into town." More and more, the case-mix intensity of our teaching hospitals in Boston inches up steadily. Currently, these teaching hospitals are doing pretty well financially, but I think that this will be temporary. Case-mix intensity, plus the promised DRG national rate when it applies fully to our comparatively high costs in Boston hospitals, seems guaranteed to cause real hardship within a couple of years.

The second explanation for the relatively better occupancy experience of our inner city referral hospitals is, I believe, that the customer is going more to the care sites where he thinks he will find "quality." Though this is never well defined, I believe that the public is still impressed by the long standing good reputations of our Boston teaching hospitals. Another thing that is happening is that we are seeing in my state what I think is the beginning of the resurgence of consumerism on health issues.

Massachusetts has always been famous for its volatile egalitarianism, and for having a legislature that really fights for the rights of the "underdog," and this is still true and it is growing. After many years since the 1960s of being in a decline because consumerism, as such, was not getting government money, it is now coming back. But now new consumer lobbies are pressing for attention. Take our elderly lobby, for example. It became extremely incensed when it was announced at the time we gave up our federal waiver that we were going into DRGs like the rest of the country. They claimed to the legislature that the DRGs give an incentive to kick old people out of the hospital too soon, and they wanted protection against irresponsible behavior by hospitals and physicians. A law was passed that says in effect that if the state determines that the incentives of DRGs forced a premature discharge, the hospital is subject to a fine. The irony of this, of course, is that we are moving into a system the explicit purpose of which is to reduce days of care. In the high-length-of-stay states, like Massachusetts and New York, these incentives apply with particular force. Now, another level of government says you better not let this apply or you are at risk. One of the ironies in my state is that we have the lowest unemployment rate in

the country, a very prosperous economy, but we now have 650,000 people who have no insurance and the number is increasing. This has become such an issue that we will have a referendum on the ballot in November to decide whether the public wants a system of national health insurance in spite of all this prosperity and competition, we are on a path that is taking us in the direction of universal entitlement. By virtue of what is labeled in polite terms as "market segmentation," we are beginning to isolate the worst health risks we have. They are the ones who now have the hardest time getting decent coverage.

How much of all this that is now happening is transitional or abortive, and how much of this represents real change? First of all, and this relates to some of the things that Dr. Collentine said, I agree on the point that solo fee-for-service medicine is on the decline in a process that seems irreversible. The reason is the prevailing insecurity of the medical profession in Massachusetts in an area where we already have too many physicians. The young doctors who are coming out of Harvard are not going into solo practice. They want to join something, some kind of organized system, and I think that is really what Dr. Collentine said, whatever you might call it, medical practice in the future is going to be delivered through some kind of organization or other, and we might as well face this and adapt to it.

I know there is an awful lot of solo fee-for-service medicine in New York City but I think you can see the decline of this here too. I also think that—and this will upset Dr. Collentine—we are going to move away from open staff rather rapidly. I sense this from listening to the boards of many of our hospitals up there, particularly since it is now a buyer's market instead of a seller's market on medical care. They say: "If we let such and so on a medical staff, don't we have the right to demand that they not go out and compete with us in a private laboratory, or in their own surgicenter, or ambulatry care network?" Also, they are saying "Don't we have a right to demand that when the hospital has a social obligation to give care to the poor the medical staff must be expected to deliver on this obligation?" We have a problem where Medicaid underpays, and always has, and at one point the physicians, many of them, decided just to drop out. Obstetrics was the big issue, and it tied in partly to the malpractice crisis I referred to, but the problem is universal. We had the anomalous situation where the hospitals felt obligated to deliver obstetrical services to Medicaid patients, but the physicians would not do it. This caused a tremendous commotion in the press, and bad publicity for the hospitals. I think this is one example among many

of how interdependent, really, the practice of medicine and hospitals really are.

As we go down this trail together, we had better recognize this interdependence. You cannot have a good hospital image unless the medical staff delivers on it, or vice versa. A good program here is that the board must support the medical staff's independent professional discretion to be guided only by what is best for their patients and not by the economic interests of big government.

One of the biggest threats of the DRG system is that it is putting incentives into the delivery of care that might create new conflicts between staffs and hospitals. I think that we might as well accept that cost reimbursement is a dying and nearly dead thing for hospitals. I am not at all sure what the future design is going to be. I think the DRG system is a transitional one. They are even saying that now in Washington. At the same time, I am not sure what a good system will be. What I dislike about DRGs is what has already started to happen, which is really national price fixing. It is totally antithetical to the competitive and deregulatory strategy of the Reagan administration. How we go with capitation and tying medicine and hospitals together in risk sharing is going to take a long time to work out. I believe that we must emphasize the social values of the nonprofit hospital and its social commitment to take care of the poor. If we start backing away from this—and we are in many parts of the country—the hospitals are going to be the losers.

One of the worst words to come out of recent hospital history is the word "dumping." This is going on all over the country. Too many hospitals are finding a taxicab to ship the nonpay emergency case over to the public hospital, if indeed there happens to be one in town. I say that we must in our own best interest try to maintain the hospital's charitable commitment through these difficult times.

With the market segmentation that is now going on, I think it is quite possible that we shall have a resurgence of the political push for national health insurance. Having 35 million uninsured people could bring us close to the political flash point on this issue, both as physicians and as institutional deliverers of care. I think we need to develop more common ground between medicine and hospitals.

I also think it essential that hospitals broaden their base of services. I am talking about vertical integration. We are past the time of growth in the acute

care sector. We might as well accept as one of the givens in our equation that the real winners in the delivery sector will be the ones that can deliver in the continuum of care, with continuity of care to the individual. I think particularly of the elderly, because this "quicker and sicker" thing that is erupting all over the country relates to the perception of the elderly of earlier hospital discharges. Whether or not this is literally true, we must acknowledge that the patient's perception of it is relevant and must be responded to.

We shall never be able precisely to measure quality, but as we have more competition the public wants to go where the quality is. Price is not, despite the arguments that from some of the new zealots on the marketplace strategy, the only determinant of choice, particularly in medical care. A testimonial to this in Boston is that our expensive referral hospitals are doing much better on admissions and bed occupancy rates than most of our less expensive community hospitals. So the public goes where they think they can get quality, but as competition heats up we need desperately to develop relative measures of quality performance, not just professionally, but in terms of what the patient cares about, and this includes the amenities of care. The caring function itself that is so strongly represented by nursing is crucially important.

One concluding point that I must make is that we should be very careful about assuming that the public likes everything that is happening in our field, and I think particularly of the move toward more and more ambulatory care services as an alternative to inpatient care. It is talked about in the journals and in speeches as if this were a solution, and nobody has been hurt. But I want to read to you something that appeared in a weekly newspaper that is published in a Boston suburban weekly (*The Enterprise*, February 4, 1985) called "That's Life" by Terry Marotta. It is headlined: "No Time for Frilly Bed Jackets and Hairbows."

> It is funny how they are in hospitals these days; they do not let you be sick anymore. I had a baby a few months ago, and I was back on the street in 48 hours. In my mother's day, they let you hang around for a good two weeks with a baby, collecting floral arrangements and tying ribbons in your hair and listening to people say, "Just rest now, dear." It's not like that now, boy. These days it's in and out. One minute your baby is treading water inside you and the next he's standing on the corner waiting for the T, like everyone else. The same goes for certain surgical procedures. I went into the hospital for an operation last week. If my cat had had the same one, the vet would have kept her overnight. We humans aren't that lucky. I had my oper-

ation, with heavy-duty "night-night" anesthesia and tubes down the throat with incisions and some fancy embroidery, all in a bright and shiny little department called Day Surgery. In by ten out by two.

You take a number in Day Surgery, just like at the bakery. And then you wait your turn. Twinkly turbaned nurses circulate swinging IV bottles like altar boys swinging their incense. They pat your arm and ask you chatty little questions about your health history. This part is actually kind of fun.

The column goes on with a description of what it is like to come to in the recovery room and be hurried into a stand up position. It concludes as follows:

A large nurse wearing what seemed to be a pirate's scarf smiled broadly, gold teeth glinting, and told me to buck up. I smiled back and slid to the floor. In the end, the nurses despaired of curing me before pickup time. They got out the shovels again and pulled me to my feet. Practiced hands, propping me by the armpits, walked me to the lockers and buttoned me into my clothes. My spouse arrived with the claim check. His face wore the expression, both sheepish and reluctant, that people have at the dry cleaner's when a shameful piece of clothing comes forth with a note pinned to the plastic reading, "Sorry, we did our best." He swallowed hard and acknowledged me as his.

I rode home in the car with eyes squeezed shut against the blur and jostle of Boston traffic. We arrived at last and climbed out. I threw up in the bushes, startling the paperboy. And now, a week later, I'm just recovered enough to tell the story. There were never any floral arrangements. Nobody said to just rest, dear. It isn't like it used to be. My neighbor's cat arrived home a few minutes ago. She had some minor surgery the day before yesterday. She looks well; she looks rested. The paperboy is glad to see her. She yawns a hello to him and turning, ties a ribbon in her hair.